DOCUMENT RESUME

ED 050 394 CG 006 398

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TITLE A Decentralized Group Treatment Program.
PUB DATE [70]
NOTE 7p.

EDRS PRICE EDRS Price MF-$0.65 HC-$3.29
DESCRIPTORS Community Cooperation, *Community Involvement, Community Responsibility, *Community Services, Comprehensive Programs, Consultants, *Consultation Programs, Health, Mental Health, *Mental Health Clinics, *Mental Health Programs, Mental Illness

ABSTRACT

Old style and new style mental hospitals are criticized for not dealing directly with a person's inability to live within his community and relate effectively with significant people. The comprehensive mental health programs, which arose in reaction to the deficits of previous facilities and treatment, are viewed as frequently following a similar, if community-based, course. The Weber Mental Health Center's decentralized group treatment approach is described. Its major premise is a behavioral one: clients are not sick, but are having difficulty managing certain aspects of their lives. The program utilizes non-clinic facilities throughout the community, as well as non-clinic personnel. Their approach is viewed as a mental health rather than a mental illness approach and fits well with the consultation and education component which is basic to comprehensive mental health centers. (TL)

ED050394

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A DECENTRALIZED GROUP TREATMENT PROGRAM

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Traditionally, mental health programs throughout the country have been tied closely to facilities and very often blatantly facility oriented. This has been as true of community mental health programs as they existed in the numerous outpatient clinics throughout the nation as it has been of the more clearly institutional state hospital programs. The overall impact of this facility oriented approach has been, in some instances, destructive to those persons who found themselves residents as well as to those who participate in programs under the aegis of community mental health outpatient clinics.

The state hospital in the old style which still exists across the country is an ideal model for destroying an individual's capacity to live within his community and to relate effectively to significant persons in his neighborhood and surroundings. The old style hospital is in reality essentially custodial, and with its vegetable gardens, dairy barn and regular work assignments, is almost analogous to a commune in that it often developes for its inhabitants a particular life style that is not applicable elsewhere. While this life style may seem preferable in some instances to the way of life encountered by many of these persons outside of the institution, it is in essence an artificial and devised way of living which does not encourage in any way, creativity, the development of individual expression, or the capability of being one's own master. This is not to say that all persons entering such an institution encounter the same eventual fate. There are a great many whose families maintain ties and whose bonds with the community are strong enough to sustain them and prevent their institutionalization. For many others without these family ties or community bonds, it is easy to drift into the nurturing womb of the hospital and remain forever. This, more than anything else, accounts for the back ward of the state institution where reside the chronic, hopelessly dependent people

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called by various names such as "burned out" schizophrenic; names which really only depict the effect of the institution upon the individual.

The latter-day state mental hospitals, those called modern and innovative, those using modern approaches and having what are considered to be adequate or close to adequate staff to patient ratios, have dealt with the problem differently. That is, rather than developing a life style within the institution complete with work assignments, etc., they have concentrated on therapeutic approaches designed to encourage the individual to leave the hospital and have developed sometimes elaborate outpatient follow-up programs. They have, however, often dishearteningly had much the same results. Despite their best efforts and the fact that these hospitals usually do have creative, innovative and hard working staff, many patients have elected to remain within the confines of the hospital, or leaving it, return at regular intervals, with recurrences of their so-called illness. Again, doctors and nurses social workers, psychologists and others concerned with the manning of the institution have labeled their failure in some terms as hopeless mental illness. Staff, having to rationalize their failures, often not understanding the impact of the institution on the indivudual, shake their heads and attach to the individual the labels which in and of themselves tend to set for the person an expectation of how he will behave and lead him onward to greater dependency and less effective overall functioning. The fact is that again the individual is not being taught to deal with the things that brought him into the mental hospital. He is instead being focused inward in an attempt to exorcise the "demon" that lies within, and the facts are that often he comes to see the "demon" as too overwhelming to deal with. In addition, staff are often at a loss because distance from the patient's community prevents them from seeing the difficulties which the individual faces in his own environment and thus helping him to learn effective ways of dealing with them.

The comprehensive mental health program which has developed across the nation

has been designed to eliminate many of the problems of the traditional, as well as the modern, state hospital in that the patient is treated in his own community, and the staff is supposedly geared to working with the patient within his own environment. Distressingly, however, two things all too frequently happen. The first is that there are many patients who are not immediately helped; that is, their behavior does not seem to change radically during initial therapeutic attempts and they are then all too often determined to be incapable of residing within the community, despite the fact that the staff resides in the same community and should be able to understand both environment and patient, and the interactions of each. Those patients who are labeled as incapable of living in the community and receiving help without long-term hospitalization return to the state institution, or are sent there for the first time, where their self-esteem is seriously disturbed, their label becomes prfoundly controlling of their behavior, and they often, even at a very young age, disintegrate into custodial or institutional patients. A second distressing fact is that very often even those patients who remain in the community and are treated within the community's framework become more or less permanently attached to the comprehensive center's staff and facility. Their treatment is provided within the facility walls. Their most rewarding contacts are with the comprehensive center staff, be it doctor, social worker, psychologist or nurse, and they become, in reality, a part of the center's family. This particular approach seems to be continuing and in many community centered programs all patient-related services are under one roof, or at least services are provided in a mental health facility. This is the logical extension of the concept that the mental health patient or client is a sick person who needs medical care. The center simply replaces the hospital as the place where the "sick" person comes to get his treatment. This has the effect of causing the patient to think of himself as sick and to act as a sick person.

The Weber Mental Health Center has developed an approach which sees the patient or client of the Center as someone who has difficulty in functioning in one or many areas of his life rather than as being sick. The mental health facility is minimized. "Mental health treatment" is also minimized and most of the Center's programs are carried out in other community agencies and buildings.

The differences which characterize this approach are: 1) Shift in focus from centralized mental health facilities to host facilities in the community; 2) The use of groups rather than the more traditional individual psychotherapy approach; 3) A focus on behavior rather than feeling, utilizing a learning process to help the client or patient to develop skills to meet and resolve his everyday problems; and 4) Utilization of people indigenous to the setting in a helping role.

Weber Mental Health maintains as its sole facility an office building where staff retreat to do the necessary dictation and paper work for administrative purposes, catch up on their correspondence, and participate in staff conferences and supervisory sessions. The only clients seen regularly in the mental health offices are those coming into the Center for the first time to visit a member of the intake staff. Other client/patients occasionally drop into the Center to discuss some particular aspect of their lives or some part of their programing such as medication with a member of the Center staff. However, these are brief contacts as a rule and occur on an infrequent basis. The Weber Mental Health team operates in a variety of host facilities including churches, schools, senior citizen centers, neighborhood centers, etc. Two approaches characterize the group program within the host facility. The first approach is one of direct service. In several facilities there are groups conducted by mental health staff which are leveled at various kinds of problems. These include: marital counseling groups; multiple conjoint family therapy groups aimed at decreasing the isolation experienced by many of the chronically dependent, including aged, in our society; and, groups which are focused on special problems such

as alcoholism. The second approach characterizing these host facility groups is one in which people indigenous to the setting are utilized in a helping role, given assistance in establishing and maintaining groups and trained in the use of the group process. An example of this approach is found in the public school system where Center staff team with counselors, teachers, volunteers and others within the school in conducting groups for children having difficulty within the school setting. The method is usually to involve the counselor or teacher as a co-therapist in the group with the mental health professional slowly withdrawing and encouraging the takeover of the function by the counselor or the teacher. Eventually, the mental health professional's role becomes entirely one of consultation rather than direct service within the group, and thus he is able to provide consultation to a number of groups occuring at the same time, greatly expanding the number of persons able to be helped and making the mental health professional much more effective and efficient. Throughout the several areas where this approach is utilized, persons within the community are trained to become effective and competent interveners in a variety of difficult situations.

The overall impact of this kind of an approach is to decrease the individual's view of himself as sick, to involve him in changing his own behavior, and to provice him with the personal resources to more adequately deal with future crisis.

Weber Mental Health has, from its inception, utilized the concept that people coming for help are individuals who are having difficulty in managing some or many aspects of their life, rather than as individuals who are sick. Throughout all of its direct treatment, as well as consultation activities, the focus has been on the fact that people learn particular patterns of behavior and ways of reacting in situations and that some of these, and often many of them, are ineffective. The therapeutic or helping goal, then, is to re-educate the individual. This involves teaching new patterns of dealing with their peers and their surroundings. This in

turn has the effect of decreasing their isolation and increasing communication. This has proved a most effective approach in maintaining individuals in their community. This is primarily accomplished through the decentralized group program which assists people to stay within their community while they are learning to deal with those aspects of their lives which are causing them sufficient stress that they or someone around them seeks help from a professional. Psychiatric labeling is minimized within the mental health program and people being treated directly by the Center staff are encouraged to think of themselves not as sick, but as individuals who are able to have some impact on their own lives. Center staff present themselves as people who are able and willing to help, but indicate that the responsibility resides with the individual to help himself. This is reinforced by the fact that many lay persons are encouraged to participate in the helping process and changing behavior is seen not as an esoteric, highly specialized realm of a few professionals, but as the province of all those in regular contact with large groups of people.

The individual who meets with a group in a neighborhood church is not as apt to think of himself as sick even though there is a representative of a mental health facility present as the leader of the group. The focus is on the impact that the individual can have on his own life and the control that he is able to exert on it through the use of effective, action-oriented techniques. Within the schools many young people are helped within a setting that is not mental health oriented in a group conducted by a counselor who is a member of the school staff. A number of these young people would, without the help available through this program, eventually end up going to a mental health facility, receive a mental health label, and consequently develop many of the behaviors appropriate to that label. This is truly a mental health approach rather than a mental illness approach and neatly fits the category of consultation and education which is a basic service of the comprehensive mental health center.

The overall impact of Weber Mental Health's program has been to prevent the alienation of people from their normal peer group in the name of mental health, and to enable people to deal immediately with the most disruptive problems in their life. Weber Mental Health feels strongly that this is the only appropriate focus for mental health, that it is time to quit identifying people as ill and treating them as if only certain highly trained persons are able to provide any assistance or remedy. The effectiveness of this approach would seem to be amply demonstrated by the fact that Weber Mental Health, with a catchment area of 124,035, is currently able to operate with only three inpatient beds with little difficulty. Also, Weber Mental Health believes strongly that it has already been demonstrated that it is possible to develop skills identified as helping on the part of indigenous personnel and to increase these persons' involvement in the helping process. This is, of course, not a totally new approach, but it is in fact a logical extension of the consultation and education aspect of comprehensive mental health programing. The question is no longer whether people should be helped within the context of their own community, but rather how they might most effectively be helped within that context. It would appear, based on Weber Mental Health's experience, that the most logical, effective way is to get the mental health professional out of his office and into the community, sharing his knowledge and skills with others able to participate meaningfully in a helping role.